



## Referrals

No referrals are necessary for the following specialties:

- Gynecology (a well woman exam and visits for necessary follow-up). Additional visits require referrals.
- Podiatry.
- Chiropractic. Coverage is limited to 12 visits per year.
- Dermatology (5 visits per calendar year). Additional visits require referrals.
- Alcohol/chemical dependency treatment. Services must be provided by NHP's behavioral health network
- Mental health. Services must be provided by NHP's behavioral health network.

## Prescription Drugs

- If your Employer has elected to provide coverage for prescription drugs, you will receive a copy of a Prescription Drug Rider setting forth your prescription drug coverage.

## Member Payments When You Access Services Without PCP Referrals Under Your POS Plan

### Maximum Lifetime Benefit

Per Member

\$1,000,000

(Note: There is no Maximum Lifetime Benefit when accessing your HMO Benefit Level.)

### Deductible

Per Member, per Calendar Year

\$1,000

Per family, per Calendar Year

\$2,000

(Note: You do not pay Deductibles when accessing your HMO Benefit Level.)

### Coinsurance

For Plan Providers

70%

For Non-Plan Providers

70%

(Note: You do not pay Coinsurance when accessing your HMO Benefit Level.)

### Out of Pocket Maximum

Per Member, per Calendar Year

\$3,000

Per Family, per Calendar Year

\$6,000

(Note: See page 1 for your Out of Pocket Maximum for Co-payments under the HMO Benefit Level).

## YOUR NHP PLAN COVERAGE

**IMPORTANT NOTICE:**

Unless otherwise stated or allowed under your POS Rider, care, services or treatment not managed by your Primary Care Physician, or which are not Medically Necessary, or which are not prior authorized by NHP are not Covered Services. Services must be provided by Plan Providers, except when prior authorized, in the case of an Emergency Medical Condition or when you are accessing the POS Benefit Level. You must check your Member Handbook and POS Rider for further details relating to your coverage.

When you obtain Covered Services and supplies under your HMO Benefit Level, you will be responsible for copayments only. When you obtain Covered Services and supplies under your POS Benefit Level (that is, no referrals are obtained), you will be responsible for coinsurance and deductibles. Whether accessing benefits through your HMO Benefit Level or POS Benefit Level, you are always responsible for ensuring that the appropriate Prior Authorizations for services and supplies have been obtained.

Services & Supplies	HMO Benefit Level	POS Benefit Level (Plan Pays)
Alcohol, drug, chemical dependency <i>(Services must be provided by Psych/Care, Inc.)</i>	Maximum benefit of \$2,000 per calendar year. PCP referral not required. Outpatient: 100% after \$45 co-payment. Inpatient: limited to crisis intervention for medical detoxification only, covered at 100% for hospital admission, after \$500 co-payment per day (5 day maximum).	Benefits may only be accessed through HMO Benefit Level.
Ambulance	100% after deductible per trip; in emergency situations or when authorized by NHP to transfer you to an NHP facility.	70% of amount due to Provider by NHP after deductible.
Chiropractic services: Limited to 12 treatments per calendar year.	100% after \$45 copayment; PCP referral not required.	70% of amount due to Provider by NHP after deductible.
Dermatology	100% after \$45 office visit copayment; PCP referral not required for 5 visits per calendar year; further visits require PCP referral.	70% of amount due to Provider by NHP after deductible.
Diabetes	100% after \$45 office visit copayment; services include outpatient self management training and educational services.	70% of amount due to Provider by NHP after deductible.
DME and disposable medical supplies; Limited to a lifetime medical maximum benefit of \$2,500	100% of DME and disposable medical supplies used in connection with DME.	70% of amount due to Provider by NHP after deductible.
Emergency room services	100% after deductible per emergency room visit for emergencies (deductible for emergency room waived if patient is admitted to hospital).	Benefits may only be accessed through HMO Benefit Level.
Family Planning	100% surgical sterilization, implantable contraceptives and intrauterine birth control devices.	70% of amount due to Provider by NHP after deductible.
Gynecology	100% after \$45 office visit co-payment; PCP referral not required for one well-women exam and necessary follow-up thereto; further visits require a PCP referral.	70% of amount due to Provider by NHP after deductible.
Hearing exams <i>(children through age 17)</i> One exam per Calendar Year.	100% when performed by PCP, to determine need for hearing correction.	Benefits may only be accessed through HMO Benefit Level.
Home health services: 60 visits per calendar year or spell of illness.	100% custodial care is not covered.	70% of amount due Provider by NHP after deductible.
Home infusion services: 60 visits per calendar year or spell of illness.	100%.	70% of amount due Provider by NHP after deductible.
Hospice care: Lifetime maximum benefit of 180 days.	100% after deductible.	70% of amount due Provider by NHP after deductible.

Services & Supplies	HMO Benefit Level	POS Benefit Level (Plan Pays)
Hospital care	100% after deductible per admission for inpatient; 100% after deductible for outpatient surgery.	70% of amount due Provider by NHP after deductible
Laboratory, X-rays and other diagnostic services.	100%. \$100 co-pay for MRI, MRA, CAT, PET and nuclear testing after deductible.	70% of amount due Provider by NHP after deductible.
Mammograms: 100% for one baseline for women age 35 through 39, one every year for women age 40 and over, or more frequently based on physician's recommendation.	100%.	70% of amount due Provider by NHP after deductible.
Mastectomy	100% after applicable co-payments for breast cancer treatment, including breast reconstructive surgery following surgery to establish symmetry between breasts.	70% of amount due Provider by NHP after deductible.
Maternity care, including pre- and post- natal care, delivery and well newborn care*	100% after \$45 co-payment for initial OB visit; Inpatient: 100% for hospital admission, after deductible.	70% of amount due Provider by NHP after deductible.
Mental health (Services must be provided by Psych/Care, Inc.)	Outpatient: 100% after \$45 co-payment; maximum of 20 visits per calendar year. PCP referral not required. Inpatient: 100% for hospital admission, after \$500 copayment per day (5 day maximum) per admission; maximum benefit period of 30 days per calendar year.	Benefits may only be accessed through HMO Benefit Level.
Newborn Children*	100% after \$25 co-payment for well baby care and treatment of Illness or Injury, including congenital defects and prematurity.	70% of amount due Provider by NHP after deductible.
Organ Transplant Services	100% after applicable co-payments, after prior approval by NHP Medical Director.	70% of amount due Provider by NHP after deductible.
Osteoporosis	100% after \$45 co-payment for diagnosis and treatment of high-risk individuals.	70% of amount due Provider by NHP after deductible.
Outpatient therapies: 100% for physical (including chest physiotherapy), respiratory, speech, cardiac and occupational therapy up to 20 visits per calendar year per modality; 36 max visits for cardiac therapy.	100% after \$50 co-payment.	70% of amount due Provider by NHP after deductible.
Physical Rehabilitation: Limited to 60 days of inpatient stay for restorative physical therapy.	100%.	70% of amount due Provider by NHP after deductible.
Physician Services for Surgery	100%.	70% of amount due Provider by NHP after deductible.
Podiatry	100% after \$45 co-payment; PCP referral not required.	70% of amount due Provider by NHP after deductible.
Preventive health services	100% after \$25 co-payment.	70% of amount due Provider by NHP after deductible.
Primary Care Physician (PCP) office visit	100% after \$25 co-pay; only by your designated PCP. 100% for office surgery.	Benefits accessed only through HMO Benefit Level.
Prosthetic Devices: Limited to one prosthetic per loss of limb or eye.	100%.	70% of amount due Provider by NHP after deductible.

Services & Supplies	HMO Benefit Level	POS Benefit Level (Plan Pays)
Skilled nursing facility: Up to 120 days per calendar year or spell of illness; custodial care is not covered.	100% after deductible.	70% of amount due Provider by NHP after deductible.
Specialist office visits	100% after \$45 co-payment; PCP referral required unless direct access is allowed, as indicated. 100% for office surgery.	70% of amount due Provider by NHP after deductible.
Sterilization: Outpatient tubal ligation or vasectomy. Reversals are not covered.	100% for outpatient tubal ligation or vasectomy; Inpatient: 100% for hospital admission, after deductible.	70% of amount due Provider by NHP after deductible.
Urgent Care Center	\$50 co-payment per visit.	70% of amount due Provider by NHP after deductible.
Vision screening (children through age 17) One exam per Calendar Year.	100% when performed by PCP, to determine need for vision correction.	Benefits may only be accessed through HMO Benefit Level.

\* For coverage to begin at date of birth for newborn children, a completed and signed enrollment form must be received by the Plan within 30 days of birth and no additional premium will be charged for such 30 day period. This notice period is extended to 60 days from the date of birth with no waiver of premium for the first 30 days. If the enrollment form is not received within 60 days of birth, the newborn child will be a Late Enrollee under the Plan. You must enroll your newborn within these time periods regardless of whether your coverage is family coverage.

A full list and description of benefits are in your Member Handbook and POS Rider.

Your Member Handbook and POS Rider also list the Exclusions, Limitations and Restrictions which apply.

**You have coverage for Prescription Drugs only if your Employer/Group has elected to obtain a Prescription Drug Rider.**

# Benefit Levels When Accessing Services through Your POS Plan

Plan payment when accessing services without PCP referrals is as follows:

- When accessing a Plan Provider, Plan will pay 70% of Plan's contracted rate.
- When accessing a Non-Plan Provider, Plan will pay 70% of Plan's Usual, Customary and Reasonable rate.

Please note that if you access a Non-Plan Provider under your POS Plan, the difference between the Plan's payment of the Usual, Reasonable, and Customary charge and the Non-Plan Provider's charge will be the Member's responsibility to pay.

## PRE-CERTIFICATION REQUIREMENTS

Certain services require Pre-certification (or Prior Authorization) by the Plan. You are responsible for assuring that your treating physicians (Plan Providers and Non-Plan Providers) obtain all necessary Pre-certifications for services and that they otherwise comply with applicable UR requirements.

### FAILURE TO OBTAIN PRE-CERTIFICATIONS WILL RESULT IN A 20% DECREASE IN YOUR POS BENEFIT LEVEL

Pre-certification is required for any of the following services:

1. Inpatient stays in a hospital (including observation), rehabilitation facility and skilled nursing facility.
2. All surgery performed in an outpatient hospital or ambulatory surgery center.
3. MRIs, MRAs, CT Scans, PET Scans.
4. Sleep Studies.
5. Stress Thallium Tests.
6. Invasive Vascular Studies/EP studies.
7. Durable Medical Equipment, including insulin pumps.
8. Prosthetic and Orthotic Devices.
9. Home Health Care.
10. Outpatient Therapy- Physical, Occupational, Speech, Cardiac and Respiratory.
11. Hyperbaric O<sup>2</sup> Treatment.
12. Dialysis.
13. Chemotherapy, Radiation Therapy, Transfusions and Infusions.
14. Chronic Specialist Care.
15. Pain Management.
16. Hospice
17. Total Obstetrical Care.
18. Ultrasounds for Obstetrical Care.
19. Biophysical profiles, non-stress tests and amniocentesis.
20. Drugs: Botox, Epogen, Procrit, Lupron 11.25 mg, Prolastin, Remicaid, Synvisc/Hyalgan, Growth Hormone, Alferon and Mifeprex.

# EXCLUSIONS

*For a Complete List and Description of Exclusions, Please Consult The Member Handbook*

## **NO BENEFITS WILL BE PROVIDED FOR THE FOLLOWING SERVICES:**

- Any services not authorized by your Primary Care Physician
- Any services which are not medically necessary
- Non-emergency care outside the NHP service area
- Any stay in a hospital or skilled nursing facility longer than authorized
- Conditions for which reimbursement is available from a government agency or program
- Television, newspaper, telephone, or other personal conveniences during a hospital stay
- Custodial Care or services relating to self care
- Cosmetic items, services or surgery
- Autopsy
- Dental evaluation or treatment
- Family or marital counseling services
- Treatment for learning disabilities, mental retardation, and other developmental disorders
- Hearing aids, eyeglasses, or contact lenses
- Services determined to be investigational, experimental or obsolete
- Examinations for insurance, employment screening, or licenses
- Services paid by or received from Workers' Compensation or any occupational or disease law
- Reversal of voluntary sterilization
- Artificial insemination and related services, including in-vitro fertilization or similar assisted fertilization services
- Treatment or surgery for infertility conditions
- Termination of pregnancy unless medically necessary for the physical health of the mother or for documented fetal abnormalities
- Long term physical (including chest physiotherapy), respiratory, occupational, cardiac or speech therapy
- Corsets, shoes (including orthopedic shoes), splints, orthotics and similar items
- Air conditioners, humidifiers, dehumidifiers, whirlpools, jacuzzis, swimming pools, or other similar items
- Services provided to evaluate scholastic and/or occupational ability, performance, or potential
- Educational or vocational training and supplies, unless otherwise stated
- Treatment and/or evaluation of complications arising from any non-covered service
- Any service not listed as a Covered Service
- Treatment for Illness or Injury relating to war or due to service in the armed forces
- Keloid removal
- Genetic testing or counseling, except when there is suspected fetal abnormality
- Any items or services related to or ordered by a court of law unless otherwise a Covered Service
- Services to treat wounds, injuries, or illness acquired while committing a crime
- Vision screening for members over the age of 17
- Vision exams for eyeglasses or contact lenses
- Hearing exams for members over the age of 17
- Acupressure, acupuncture, hypnosis, biofeedback or other complementary/alternative healing methods
- Medical or surgical treatment resulting from willfully failing to follow your physician's treatment plan
- Services for routine foot care
- Services for the treatment of obesity, or Morbid Obesity
- Smoking cessation
- Pre-natal or child birth classes
- Services provided by a member of household or relation by blood or marriage
- Inpatient Hospital Services for alcohol/chemical dependency, except for detoxification or acute symptoms
- Treatment for sexual dysfunction or sex change operations
- Charges or fees incurred from any non-Member of Neighborhood Health Partnership
- Private duty nurses
- Emergency room visits for an illness or injury that is not an emergency
- Charges which exceed usual, customary and reasonable charges for non-contracted Providers
- Treatment of a condition or complication resulting from being under the influence of alcohol or due to illegal drug use
- Prescriptions for outpatient medications, over the counter drugs and other medical supplies and equipment
- Illness or Injury resulting from participation in hazardous recreational activities
- Weight control, weight loss, health and fitness programs or nutritional consultants
- Circumcision, except within 30 days of birth or when Medically Necessary
- Treatment for erectile dysfunction, including penile implants
- Wigs or cranial prosthetics

*See your Member Handbook for a complete list and description of Exclusions and other Limitations.*



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